

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

6685

06663

1. PLACE OF DEATH a. COUNTY CECIL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY CECIL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CONOWINGO Rural				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CONOWINGO Rural			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last DAVID ELBERT CALDWELL			4. DATE OF DEATH Month Day Year 6/ 12/ 19 61				
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/ 19/ 1894		9. AGE (In years last birthday) 67 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABOR RET.		10b. KIND OF BUSINESS OR INDUSTRY FIBER MILL		11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DAVID CALDWELL				14. MOTHER'S MAIDEN NAME DORA PARKS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 233-07-9057		17. INFORMANT Mrs William Sheets Conwingo Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Bronchial Asthma 523.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Silicosis DUE TO (c) Work in Coal mines INTERVAL BETWEEN ONSET AND DEATH 25 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 12, 1961 that (I) (we) last saw the deceased alive on June 12, 1961 and that death occurred at 11:30 PM from the causes and on the date stated above.							
22a. SIGNATURE F.B. Robinson		M.D. ATTENDING PHYS. F.B. Robinson, M.D.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS Oxford Pa					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/15/1961		23c. NAME OF CEMETERY OR CREMATORY CONOWINGO BAPTIST CEM. CONOWINGO		23d. LOCATION (City, town, or county) (State) MD.	
24. FUNERAL DIRECTOR'S SIGNATURE Edmon E McMiller		ADDRESS		25a. REC'D BY REGISTRAR JUN 16 '61		25b. REGISTRAR'S SIGNATURE Arthur L. House	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

RISING SUN, MD.

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CECIL

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CONWINGO

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CONWINGO

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CALDWELL

ELBERT

DAVID

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4/19/1894

Y

WHITE

MAIR

U.S.A.

VIRGINIA

RYAN WILL

RYAN

LABOR

DORA PARKS

CALDWELL

DAVID

233-07-9027 for William Sheets Conwingo Md.

NO

CONWINGO BAPTIST CH. CONWINGO

01/11/02

Bural

WISING SUB. MD.

Arthur S. Kraus

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East Virginia

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Miss G. Knox

David A. (deceased)

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DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, for its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS. AISME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6687

06671

1. PLACE OF DEATH a. COUNTY Cecil										2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Cecil											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton										c. LENGTH OF STAY IN 1b 15 Mos.											
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital										d. STREET ADDRESS Elk Mills											
3. NAME OF DECEASED (Type or print) WILLIAM										4. DATE OF DEATH June 21 1961											
5. SEX Male										6. COLOR OR RACE White											
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										8. DATE OF BIRTH Jan. 21, 1933											
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stone Quarry										9b. KIND OF BUSINESS OR INDUSTRY Laborer											
10a. BIRTHPLACE (State or foreign country) West Virginia										11. CITIZEN OF WHAT COUNTRY USA											
12. FATHER'S NAME Finnice Day										13. MOTHER'S MAIDEN NAME Mamie Cuddlings											
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes										15. SOCIAL SECURITY NO. 236-50-2775											
16. INFORMANT Mrs. Shirley M. Day										17. ADDRESS Elk Mills, Md.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Massive intra-abdominal hemorrhage 9/2.2 DUE TO (b) Massive lacerations of liver Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Crushing injuries of body																				INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.										20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Caught in rock crusher while at work											
20c. TIME OF INJURY 7:30 p.m. 6/21/61										20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Elk Mills										20f. (City or town) Cecil (County) Md. (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																					
ACTUAL SIGNATURE W. Bradley King, Jr.										CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 6/21/61											
EXAMINER'S NAME (Type) W. Bradley King, Jr., M.D.										Address (Street, city, town, or county)											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial										22b. DATE THEREOF June 25, 1961											
22c. NAME OF CEMETERY OR CREMATORY Nuttall Cemetery										22d. LOCATION (City, town, or country) Edmond, West Virginia (State)											
23. FUNERAL DIRECTOR PIPPIN FUNERAL HOME										24a. REC'D BY REGISTRAR JUN 23 '61											
24b. REGISTRAR'S SIGNATURE Arthur S. Knead																					



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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS. AISME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06672

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East		c. LENGTH OF STAY IN b. 30 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS North East		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ambrose E. Drennen		4. DATE OF DEATH Month June Day 18 Year 1961			
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 3, 1886	9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months 7 Days 18
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk Retired		10b. KIND OF BUSINESS OR INDUSTRY Garage		11. BIRTHPLACE (State or foreign country) Penna	
13. FATHER'S NAME Walker Drennen		14. MOTHER'S MAIDEN NAME Elizabeth Gregg			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs Emma T. Drennen North East, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterior Sclerosious DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 10 min 10 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE R.C. Dodson M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) R.C. Dodson M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) (State)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 21, 1961	22c. NAME OF CEMETERY OR CREMATORY North East Methodist	22d. LOCATION (City, town, or county) North East, Cecil Co., Md		
23. FUNERAL DIRECTOR Joseph R. Grant		24a. REC'D BY REGISTRAR June 21 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after de

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the registrar must be notified. Then please remove carbon papers. Pages 1 and 2 should be retained by the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7852

CERTIFICATE OF DEATH

Reg. Dist. No. 07843

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <u>INFANT</u> First Middle Last <u>Ferrese</u>		4. DATE OF DEATH Month <u>June</u> Day <u>24</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 23, 1961</u>
9. AGE (In years lost birthday) yrs. <u>2</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13. FATHER'S NAME <u>Frederick J. Ferrese</u>	14. MOTHER'S MAIDEN NAME <u>Shirley Kemethier</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. <u>INFORMANT</u>	Address <u>Frederick J. Ferrese, Elkton, Md.</u>
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Respiratory Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Septicemia</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from <u>6/23</u> , 19 <u>61</u> , to <u>6/24</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>6/24</u> , 19 <u>61</u> , and that death occurred at <u>1:30</u> P. M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state)	DATE SIGNED <u>6/24/61</u>
ACTUAL SIGNATURE <u>Peter Stankovich</u>		M.D. <u>ELKTON MD</u>	
PHYSICIAN'S NAME (Type) <u>PETER STANKOVICH, M.D.</u>			

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>JUNE 24, 1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Elkton Memorial Park</u>	22d. LOCATION (City, town, or county) (State) <u>Elkton, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph E. Ricks</u>		24. REC'D BY REGISTRAR <u>DATE</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur J. K...</u>

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
6689 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 66673

1. PLACE OF DEATH a. COUNTY Cecil		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b D.O.A.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md.		b. COUNTY Cecil		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East R.D.1		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Union Hospital		4. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		5. SEX James		6. COLOR OR RACE Curtis		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Gambill 7-2-1890		9. AGE (in years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Hilton, N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John William Gambill		14. MOTHER'S MAIDEN NAME Martha Denney		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-38-8780		17. INFORMANT Amanda Brooks Gambill, North East, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Laceration of throat both juglarveins and carotids arteries and larynx anteriorly		DUE TO (b)		DUE TO (c)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		Driving a tractor and was caught by cloths line		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (See nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year 3, 20 6 28 19 61		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Farm		20f. (City or town) North East		20g. (County) Cecil		20h. (State) Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE R.C. Dodson		EXAMINER'S NAME (Type) R.C. Dodson		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER Rising Sun, Md.		DATE SIGNED 6-30-61					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-1-1961		22c. NAME OF CEMETERY OR CREMATORY Conowingo Cem.		22d. LOCATION (City, town, or country) Conowingo		22e. (State) Md.		23. FUNERAL DIRECTOR James E. M. Helton		24. REC'D BY REGISTRAR Rising Sun, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. House		DATE JUL 3 '61	

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TO HOSPITAL: The law requires that the death certificate be retained within 24 hours after death. Page 4 of this certificate is to be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6690

06674

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Elkton c. LENGTH OF STAY IN b 32 Yrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Union Hospital, Elkton, Md.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Cecil c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Elkton d. STREET ADDRESS 220 East High Street Elkton, Maryland	
3. NAME OF DECEASED (Type or print) Cora L Johnson		4. DATE OF DEATH Month 6 Day 20 Year 1961	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 5, 1903
9. AGE (In years) 58 yrs.		10. IF UNDER 1 YEAR Months 5 Days 10	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11. BIRTHPLACE (County & State, or foreign country) Orange County, Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James Morton		14. MOTHER'S MARDEN NAME Patsy Reynolds	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Lewis Johnson		Address 220 East High Street Elkton, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Uterus with Metastasis 174X DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c) _____			
INTERVAL BETWEEN ONSET AND DEATH 8 Mos.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING () OR CONTRIBUTING () CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from 1/12/ , 19 61 to 6/20/ , 19 61 that (I) (we) last saw the deceased alive on 6/20/ , 19 61 , and that death occurred at 9 PM , from the causes and on the date stated above.			
22a. SIGNATURE James L. Johnson		22b. DATE SIGNED 6/23/61	
22c. PHYSICIAN'S NAME (Type) James L. Johnson M.D.		22d. ADDRESS 245 East High Street Elkton, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-24-61	
23c. NAME OF CEMETERY OR CREMATORY Berkley Cemetery		23d. LOCATION (City, town or county) (State) Darlington Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Charles J. Bullock - Hance de Gruy, Inc.		25a. REC'D BY REGISTRAR JUN 27 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Evans			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6691

06675

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point c. LENGTH OF STAY in 1b 27 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Harford c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Street d. STREET ADDRESS RD 2, Box 106 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JESSE E. KITTS		4. DATE OF DEATH Last June 2 1961		9. AGE (In years last birthday) 73 IF UNDER 1 YEAR Months 2 Days 2 Hours 61 Min.			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH 6-20-87 WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer (retired)		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (County & State, or foreign country) Virginia			
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Harvey John Kitts (deceased)		14. MOTHER'S MAIDEN NAME Sarah Williams (deceased)			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes 16. SOCIAL SECURITY NO. WW-I 229-05-8281		17. INFORMANT Hospital Records, VAH, Perry Point, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of stomach DUE TO (b) Metastasis to the liver with massive destruction of liver parenchyma DUE TO (c) unknown PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) unknown							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. VA 19 1961 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) VA			
20f. (City or town) VA		20g. (County) VA		20h. (State) VA			
21. I certify that Dr. A. L. Mooney attended the deceased from April 6, 1961 to June 2, 1961 and that death occurred June 2, 1961 from the causes and on the date stated above.							
22a. SIGNATURE A. L. Mooney		22b. DATE SIGNED 6-2-61		22c. PHYSICIAN'S NAME (Type) A. L. MOONEY, Asst. Clinical Pathologist, V.A. Hospital, Perry Point, Md.			
23a. BURIAL, CREMATION REMOVAL (Specify) June 5, 1961		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY Belair Memorial Gardens			
23d. LOCATION (City, town or county) Belair, Maryland		23e. (State) Md.		23f. ADDRESS McComas Funeral Home, Abingdon, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE McComas Funeral Home		25a. REC'D BY REGISTRAR JUN 7 '61		25b. REGISTRAR'S SIGNATURE Anthony S. Kraus			

TO HOSPITAL: The law requires that the death certificate be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

permitted

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 06676

6692

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admittance) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN lb 14 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		d. STREET ADDRESS Elkton R. D. X	
3. NAME OF DECEASED (Type or print) ROBERT KEMP MAC NEAL		4. DATE OF DEATH Month June Day 26, Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 31, 1876
9. AGE (In years last birthday) 84 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Sales	
11. BIRTHPLACE (State or foreign country) Cherry Hill, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George W. Mac Neal		14. MOTHER'S MAIDEN NAME Indiana Logan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 284-10-6478	
17. INFORMANT Mrs. Carmen A. Mac Neal, R.D. Elkton, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4 24 DUE TO ACUTE PULMONARY EDEMA (b) DUE TO CONGESTIVE HEART FAILURE (c) DUE TO CORONARY HEART DISEASE, AHD. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) CANCER OF PROSTATE		INTERVAL BETWEEN ONSET AND DEATH 1 hour 6 min 6 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year 19 61 Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 1953 to 6/26 1961, that I last saw the deceased alive on 6/26 1961, and that death occurred at 2:40 A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Peter Stankis M.D.		ADDRESS (Street, city or town, state) ELKTON MD DATE SIGNED 6/26/61	
PHYSICIAN'S NAME (Type) PETER STANKIS			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-28-61	22c. NAME OF CEMETERY OR CREMATORY Whitmarsh Mem. Pk.	22d. LOCATION (City, town, or county) (State) Whitmarsh, Penna.
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS PIPPIN FUNERAL HOME 1401 E. Elkton, Md.		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE	

Arthur S. Kraus



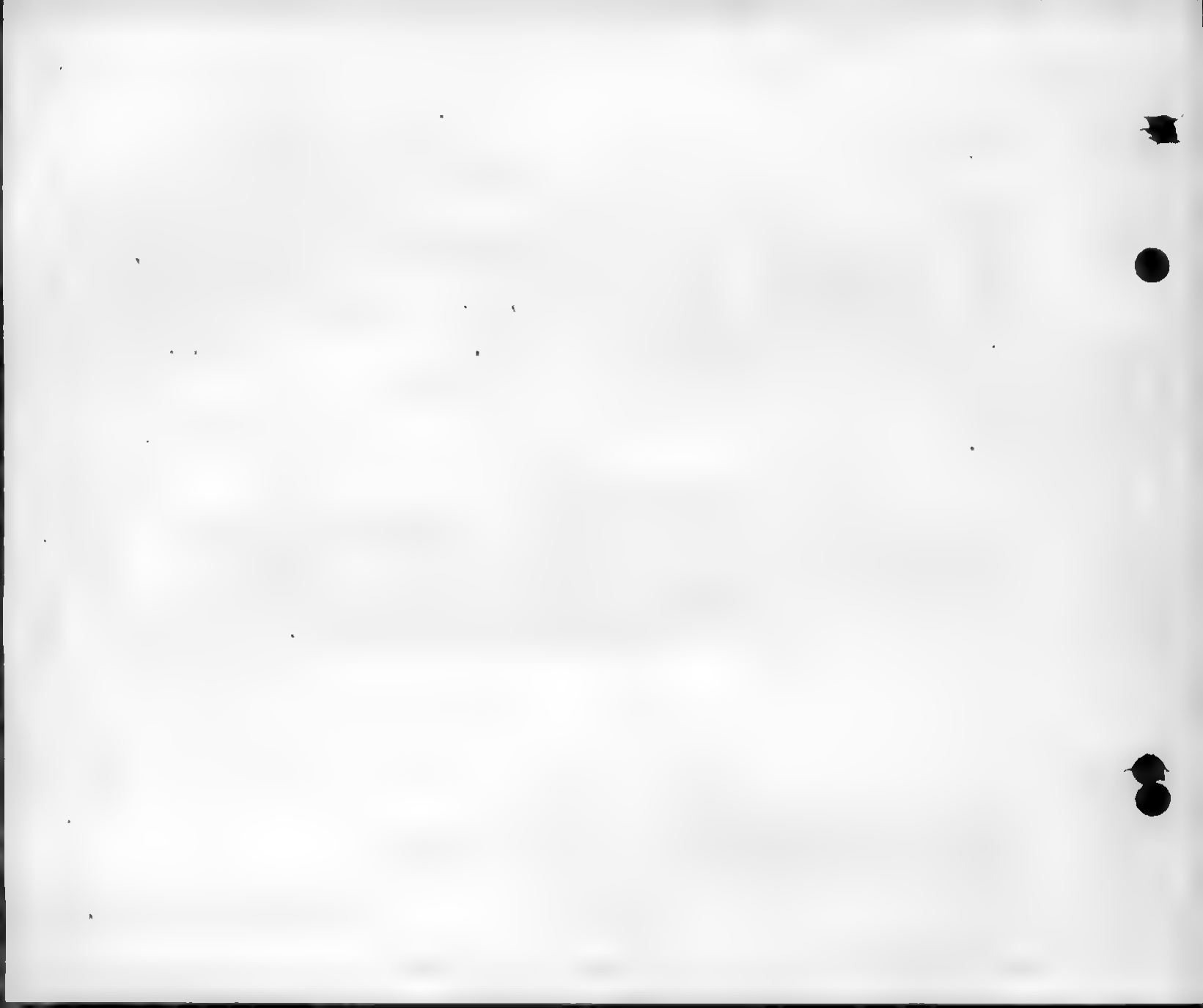
CERTIFICATE OF DEATH

Reg. Dist. No. 06677

6693

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Cecilton,		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Cecilton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Home		d. STREET ADDRESS /	
3. NAME OF DECEASED (Type or print) First Bertha Middle Dixon Last Manlove		4. DATE OF DEATH Month June Day 9 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May, 16, 1914
9. AGE (In years last birthday) 47 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Leonard Dixon		14. MOTHER'S MAIDEN NAME Anna Holden	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. Homer Manlove, (Husband) Cecilton, Md;	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 170X (b) Far-advanced Ca of breast with metastatic spread. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Complete replacement of liver with Ca with marked jaundice.		INTERVAL BETWEEN ONSET AND DEATH 12 hours 6 years.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb , 19 61 , to June 9 , 19 61 , that I last saw the deceased alive on 9 June , 19 61 , and that death occurred at 5:00A M, from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED 6.10.61			
ACTUAL SIGNATURE Wallace Chenshain M.D.			
PHYSICIAN'S NAME (Type) Wallace Chenshain, M.D.		Cecilton Md.	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June, 11, 1961	22c. NAME OF CEMETERY OR CREMATORY Cecilton Cemetery	22d. LOCATION (City, town, or county) (State) Cecilton, Cecil Co; Md.
23. FUNERAL DIRECTOR'S SIGNATURE Edward Bellows, Millington, Md.		24a. REC'D BY REGISTRAR JUN 13 '61	24b. REGISTRAR'S SIGNATURE Arthur S. King

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained in the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute first certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health. Its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6694

06678

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital		d. STREET ADDRESS 215 Meadow View,	
3. NAME OF DECEASED (Type or print) First JOSEPH Middle F. Last McCANN		4. DATE OF DEATH Month 6 Day 25 Year 1961	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-10-97
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager of Laundry		10b. KIND OF BUSINESS OR INDUSTRY Laundry	
13. FATHER'S NAME FRANCIS McCANN		14. MOTHER'S MAIDEN NAME MARY Kramer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) YES WW I		16. SOCIAL SECURITY NO. 156-07-9172	
17. INFORMANT Mrs. Joseph F. McCann, 215 Meadow View Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion and Oedema of Lungs 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE R.C. Dodson		DATE SIGNED 6-25-61	
EXAMINER'S NAME (Type) R.C. Dodson M.D.		DEPUTY MEDICAL EXAMINER Rising Sun Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JUNE 28, 1961	
22c. NAME OF CEMETERY OR CREMATORY GRACE LAWN MEM. PARK, FARMHURST, DEL.		22d. LOCATION (City, town, or country) (State)	
23. FUNERAL DIRECTOR PIPPIN FUNERAL HOME, South Dr. Md.		24a. REC'D BY REGISTRAR DATE JUN 27 '61	
24b. REGISTRAR'S SIGNATURE			

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Guidelines 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

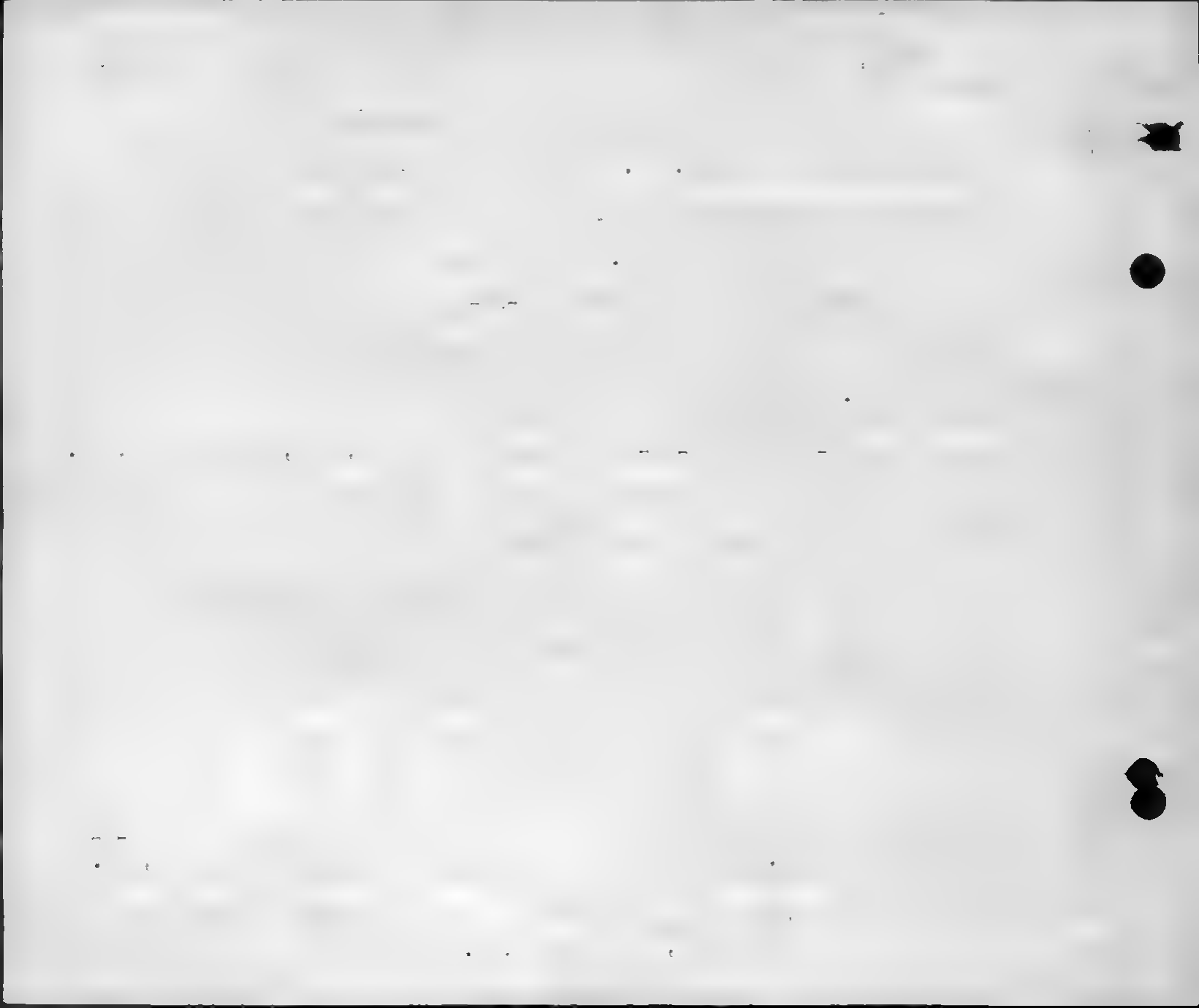
VS. A15ME
5M 7/59

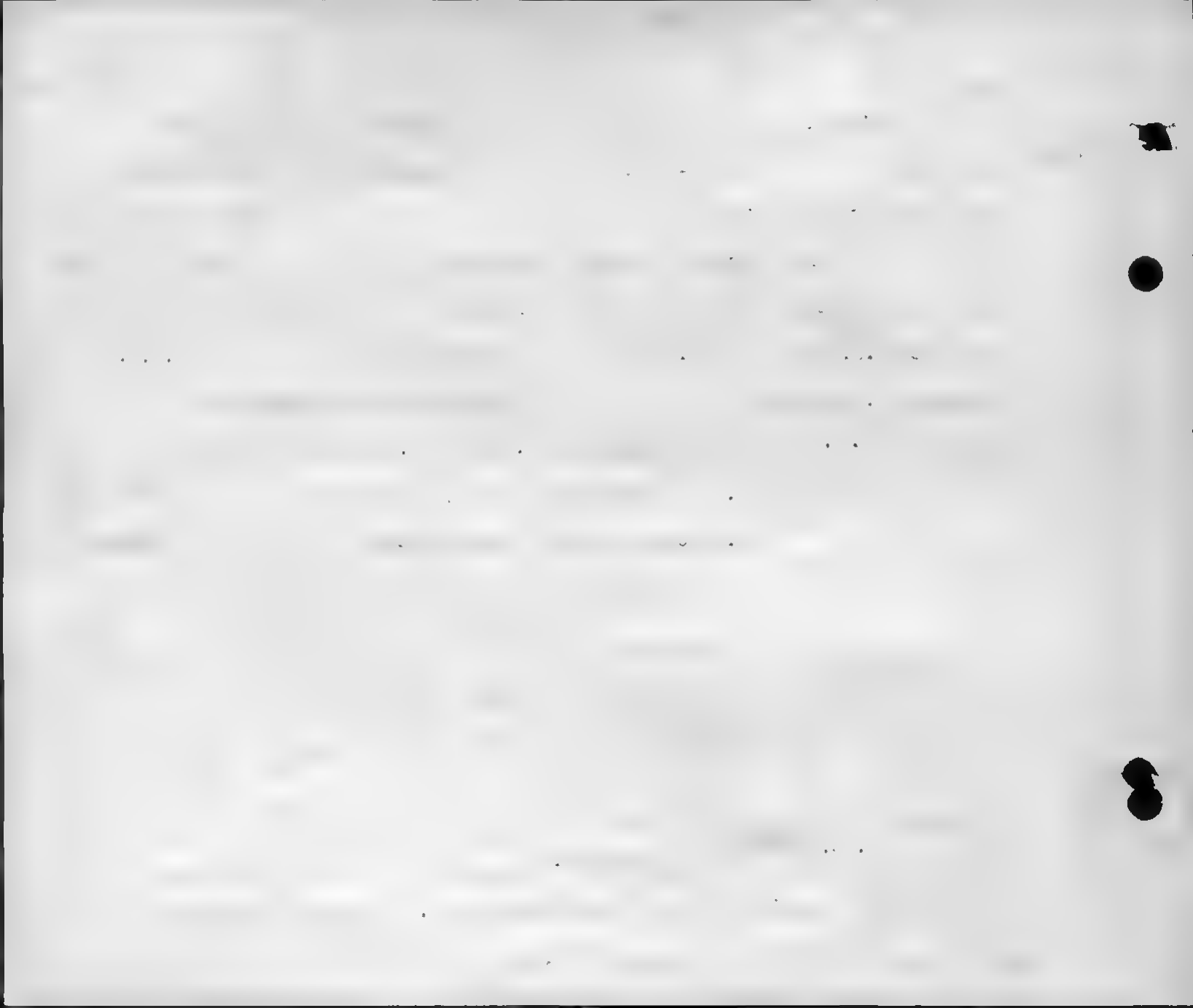
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
6695 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 06679

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Virginia	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Alexandria	
c. LENGTH OF STAY IN 1b 6yrs. 3mo. 20days		d. STREET ADDRESS 5 Leadbetter	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital			
3. NAME OF DECEASED (Type or print) HOMER L. MC INTURFF		4. DATE OF DEATH June 1 1961	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-19-24	
9. AGE (In years last birthday) 36		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		11. BIRTHPLACE (State or foreign country) Virginia	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Carl O. Mc Inturff		14. MOTHER'S MAIDEN NAME Bessie Tyndall	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW-II		16. SOCIAL SECURITY NO. 224-22-1869	
17. INFORMANT Hospital Records, VAH, Perry Point, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1. Pneumonitis, bilateral, severe, with bronchopneumonia.			
(b) 2. Grand mal and petit mal epilepsy.			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE R. C. DODSON		DATE SIGNED 6-2-61	
EXAMINER'S NAME (Type) R. C. DODSON		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 5, 1961	
22c. NAME OF CEMETERY OR CREMATORY Ivy Hill		22d. LOCATION (City, town, or country) (State) Alexandria, Virginia	
23. FUNERAL DIRECTOR W. B. Cunningham		24a. REC'D BY REGISTRAR JUN 7 '61	
Cunningham Funeral Home, Alexandria, Va.		24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

MEDICAL CERTIFICATION

INTERVAL BETWEEN ONSET AND DEATH 60 hours
Unknown





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6697

06681

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Md.	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chesapeake City R.D.		c. LENGTH OF STAY IN 1b 20 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS Chesapeake City R.D.	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First Sallie Middle Elizabeth Last Miller		Month 6 Day 14 Year 19 61	
5. SEX F		6. COLOR OR RACE W.	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-27-1875	
9. AGE (In years last birthday) 85 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Thomas Johnson		14. MOTHER'S MAIDEN NAME Sarah Martha Cathcart	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. Bob Miller, Chesapeake City, Md.	
17. INFORMANT Bob Miller, Chesapeake City, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio Sclerosis DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>R.C. Dodson</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) R.C. Dodson		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/16/61	
22c. NAME OF CEMETERY OR CREMATORY New Freedom Cemetery		22d. LOCATION (City, town, or country) (State) New Freedom, Penna.	
23. FUNERAL DIRECTOR PIPPIN FUNERAL HOME		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE Elkton, Md. 19 61	

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HEALTH DEPT.
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

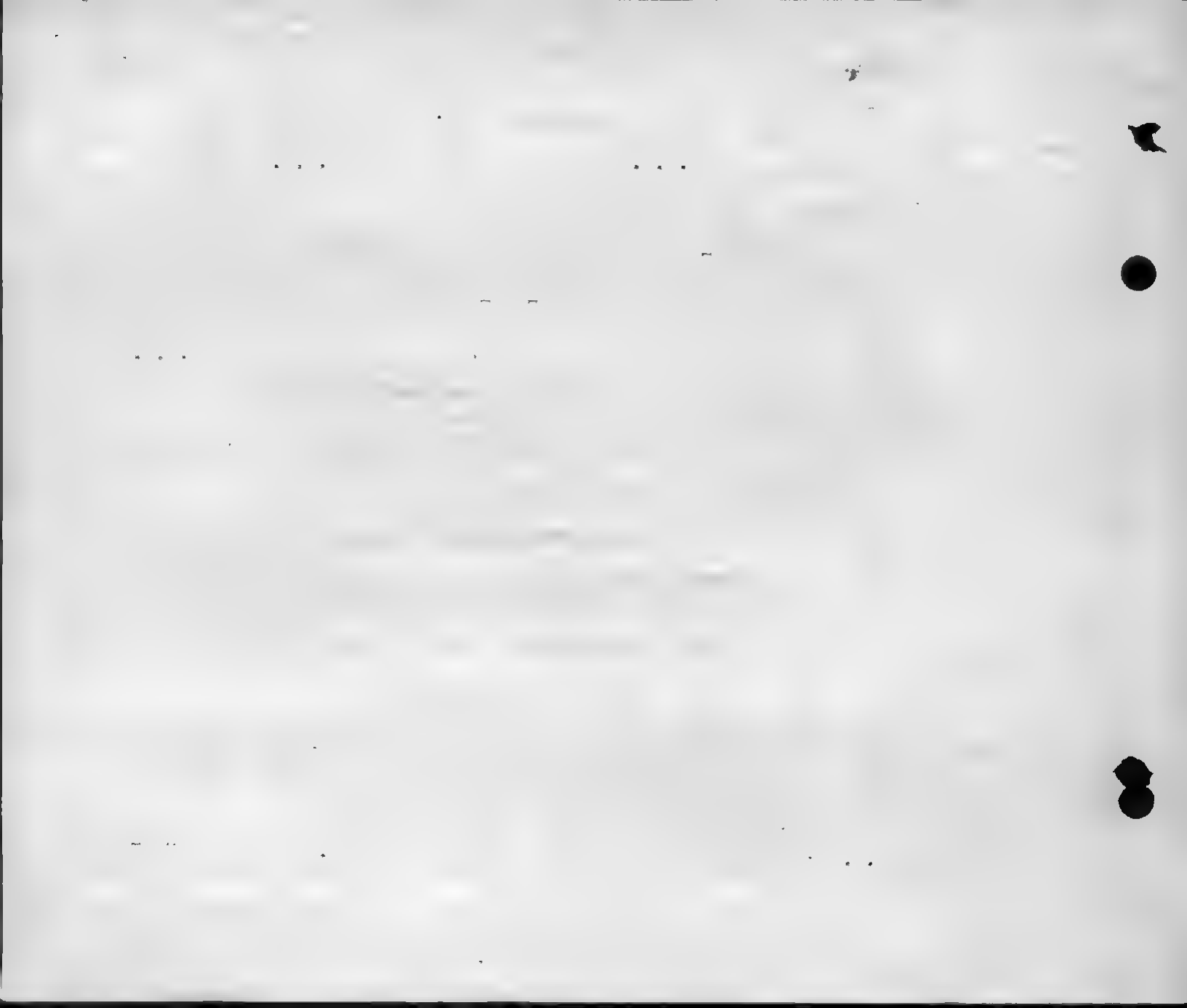
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

C698

06682

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheapeake City R.F.D.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last Benjamin M Nuble		4. DATE OF DEATH Month Day Year 6 9 1961	
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-13-1922
9. AGE (In years last birthday) 39 yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Benjamin Nuble		14. MOTHER'S MAIDEN NAME Edna Washington	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Edna Nuble, Chesapeake City, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion 72000 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) and hypertension PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II. of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE R.C. Dodson		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) R.C. Dodson		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER Rising Sun, Md.		DATE SIGNED 6-10-61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/14/61	
22c. NAME OF CEMETERY OR CREMATORY Bohemia Manor Cem.		22d. LOCATION (City, town, or country) (State) Bohemia Manor, Md.	
23. FUNERAL DIRECTOR Edw. R. Bell		ADDRESS 909 Poplar St.	
24a. REC'D BY REGISTRAR DATE JUN 16 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

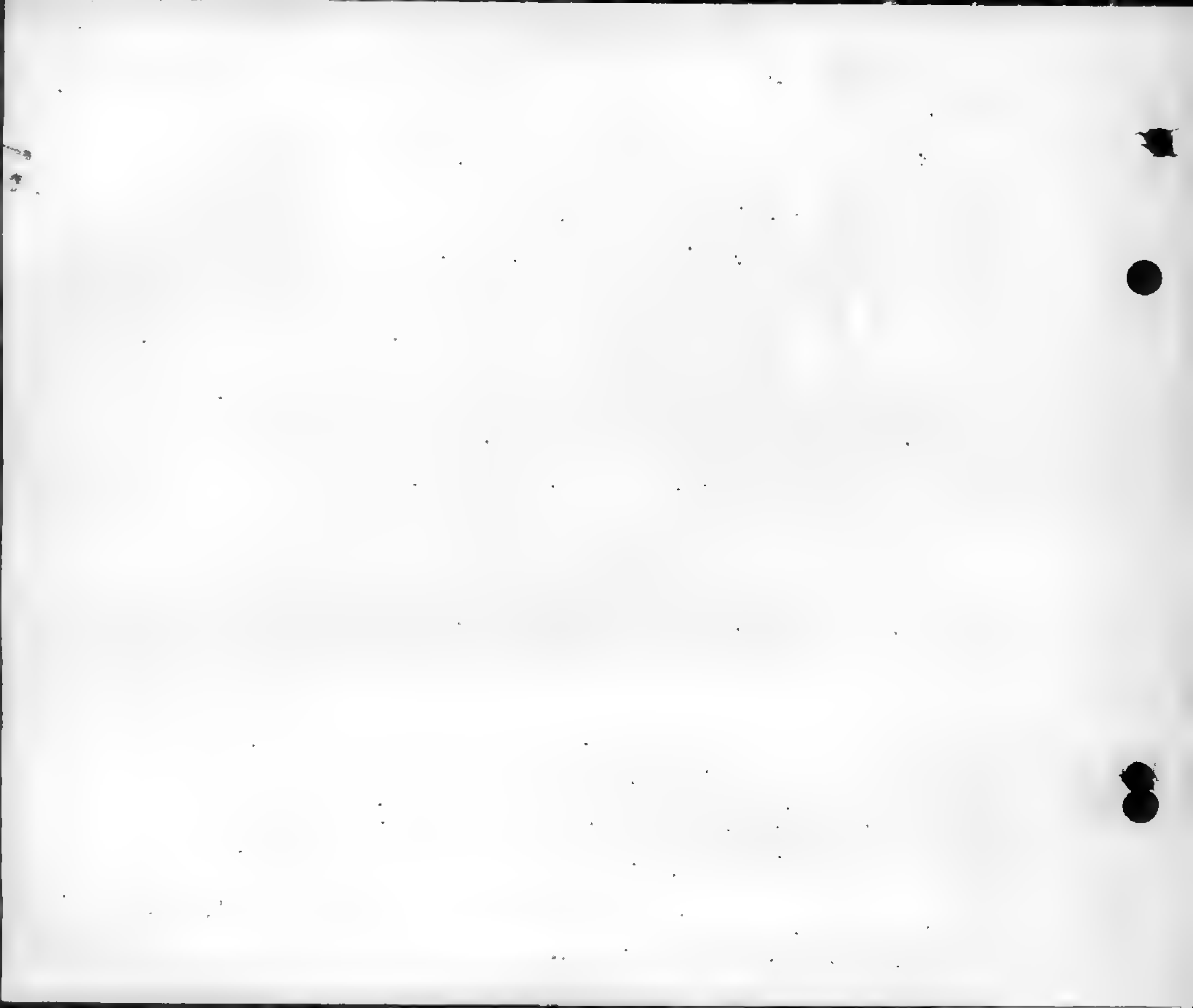
CERTIFICATE OF DEATH

Reg. Dist. No.

06683

1. PLACE OF DEATH a. COUNTY <u>CECIL</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>CECIL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>		c. LENGTH OF STAY IN 1b. <u>2 1/2 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Elkton Hospital - Elkton, MD</u>				d. STREET ADDRESS <u>1</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>HARRY</u> Middle <u>E.</u> Last <u>Patchell</u>				4. DATE OF DEATH Month <u>6</u> Day <u>6</u> Year <u>1961</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>11/30/1874</u>		9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>2</u> Hours <u>1</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>OXFORD, PA</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>JOHN Patchell</u>				14. MOTHER'S MAIDEN NAME <u>MARY FINLEY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>UNKNOWN</u>				16. SOCIAL SECURITY NO. <u>UNKNOW</u>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Edema of Lungs & Viscera</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Nephritis</u> (c) <u>Coronary Artery Disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>10 MINUTES</u> <u>30 YEARS</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Accident</u>							
18. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. TIME OF INJURY Month, Day, Year Hour <u>0</u> m. <u>19</u> p. m.		20b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>			
20d. (City or town) <u>Elkton</u>		(County) <u>Cecil</u>		(State) <u>MD</u>			
21. I certify that I attended the deceased from <u>5/13, 1961</u> to <u>6/6, 1961</u> that I last saw the deceased alive on <u>6/3, 1961</u> , and that death occurred at <u>8 PM</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. Randall Jones</u> M.D.				ADDRESS (Street, city or town, state) <u>201 E. Main St. Elkton, MD</u>			
PHYSICIAN'S NAME (Type) <u>J. Randall Jones</u>				DATE SIGNED <u>6/6/61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/6/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cherry Hill Cemetery</u>			
22d. LOCATION (City, town, or county) <u>Cherry Hill, Md.</u>		(State) <u>MD</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph E. Hicks</u>				ADDRESS <u>Elkton, Md.</u>			
24a. REC'D BY REGISTRAR <u>JUL 10 '61</u>		24b. REGISTRAR'S SIGNATURE <u>S. H. Hume</u>					

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or funeral home for 30 days after the date of death. After this certificate has been signed by the attending physician and completely filled in by the funeral director, the page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6700

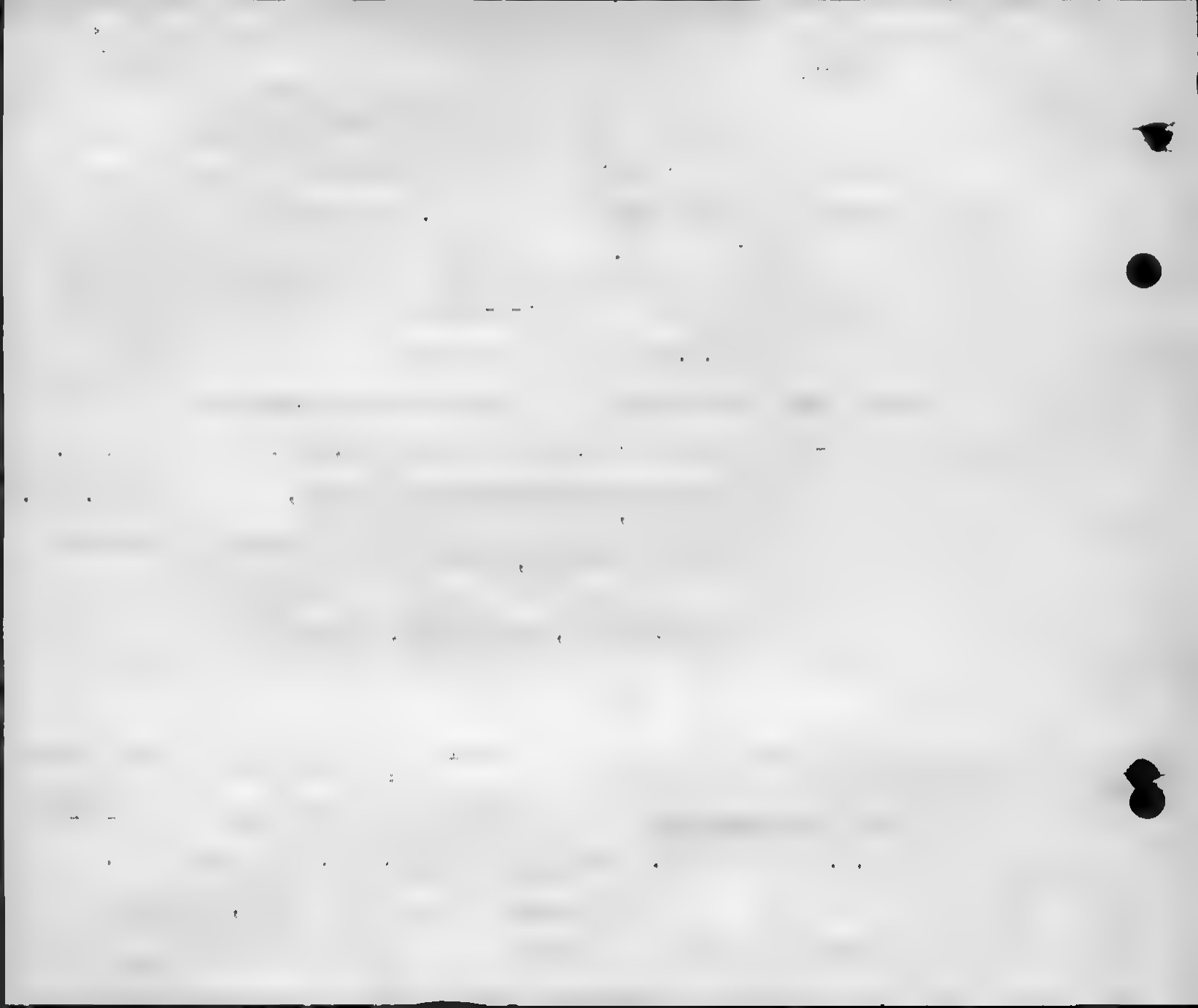
06684

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point c. LENGTH OF STAY in lb 8 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Virginia b. COUNTY ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington d. STREET ADDRESS 3905 N. Pershing Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) TRUBY A.		4. DATE OF DEATH Month June Day 27 Year 19 61	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-3-97	
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months 6 Days 4	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government	
11. BIRTHPLACE (County & State, or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Benjamin Truby (deceased)		14. MOTHER'S MAIDEN NAME Martha NuFall (deceased)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW-I		16. SOCIAL SECURITY NO. 578-32-7397	
17. INFORMANT Hospital Records, VAH, Perry Point, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Encephalomalacia of cerebral cortex, bilateral, due to arteriosclerosis DUE TO (b) Arteriosclerosis of the internal carotid artery, bilateral, severe DUE TO (c) unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis, generalized, severe			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. VA 19 61 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that A.L. Mooney attended the deceased from June 19, 1961, to June 27, 1961 , and that death occurred at 1:00 pm on the causes and on the date stated above.			
22a. SIGNATURE A.L. Mooney		22b. DATE SIGNED 6-27-61	
22c. PHYSICIAN'S NAME (Type) A.L. MOONEY		22d. ADDRESS Asst. Clinical Pathologist, VAH, Perry Point, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-30-61	
23c. NAME OF CEMETERY OR CREMATORY unknown WALNOT GROVE		23d. LOCATION (City, town or county) (State) Boonville, Missouri	
24. FUNERAL DIRECTOR'S SIGNATURE Ives Funeral Home, Arlington, Virginia		25a. REC'D BY REGISTRAR JUN 29 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Howard			

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. The law requires that the death certificate be completed by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6701

CERTIFICATE OF DEATH

Reg. Dist. No. 06685

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Elkton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Devine Nursing Home		d. STREET ADDRESS RD #4	
3. NAME OF DECEASED (Type or print) First Charles Middle Robinson Last Robinson		4. DATE OF DEATH June 28 1961	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-10-83
9. AGE (In years last birthday) 78 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic	
11. BIRTHPLACE (State or foreign country) Christiana, Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Robinson		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. [If yes, give war or dates of service]	
17. INFORMANT Carl A. Robinson		Address RD #4 Elkton	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease, Decomp. 120.0 DUE TO (b) Arteriosclerosis, Generalized, Seven years DUE TO (c) [blank]			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1960, to 6-28, 1961, that I last saw the deceased alive on 6-28, 1961, and that death occurred at 7:50 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Tillman D. Johnson M.D.		ADDRESS (Street, city or town, state) 123 SINGERLY AVE	
PHYSICIAN'S NAME (Type) Tillman D. Johnson		DATE SIGNED Elkton, Md.	
22a. BURIAL CREMATION, (Specify) Burial		22b. DATE THEREOF 6-30-61	
22c. NAME OF CEMETERY OR CREMATORY Chelton Hill Cemetery		22d. LOCATION (City, town, or county) (State) Phila. PA.	
23. FUNERAL DIRECTOR'S SIGNATURE PIPPIN FUNERAL HOME Donald W. Pippin		ADDRESS ELKTON, MARYLAND	
24a. REC'D BY REGISTRAR DATE III 3 '61		24b. REGISTRAR'S SIGNATURE Robert S. Kram	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the following information: 1. Name of deceased, 2. Date of death, 3. Place of death, 4. Cause of death, 5. Usual residence, 6. Date of birth, 7. Sex, 8. Color or race, 9. Age, 10. Usual occupation, 11. Birthplace, 12. Citizen of what country, 13. Father's name, 14. Mother's maiden name, 15. Was deceased ever in U. S. Armed Forces, 16. Social Security No., 17. Informant, 18. Cause of death, 19. Was autopsy performed, 20. Accident was underlying or contributing cause of death, 20a. Time of injury, 20b. Describe how injury occurred, 20c. Place of injury, 20d. Injury occurred while or not while at work, 20e. Place of injury, 20f. (City or town), (County), (State), 21. I certify that I attended the deceased from Jan 1960, to 6-28, 1961, that I last saw the deceased alive on 6-28, 1961, and that death occurred at 7:50 AM, from the causes and on the date stated above. ACTUAL SIGNATURE Tillman D. Johnson M.D. ADDRESS (Street, city or town, state) 123 SINGERLY AVE PHYSICIAN'S NAME (Type) Tillman D. Johnson DATE SIGNED Elkton, Md. 22a. BURIAL CREMATION, (Specify) Burial 22b. DATE THEREOF 6-30-61 22c. NAME OF CEMETERY OR CREMATORY Chelton Hill Cemetery 22d. LOCATION (City, town, or county) (State) Phila. PA. 23. FUNERAL DIRECTOR'S SIGNATURE PIPPIN FUNERAL HOME Donald W. Pippin ADDRESS ELKTON, MARYLAND 24a. REC'D BY REGISTRAR DATE III 3 '61 24b. REGISTRAR'S SIGNATURE Robert S. Kram



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

06686

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Delaware b. COUNTY New Castle	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Penn	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 224 E. Main Street		d. STREET ADDRESS 1712	
3. NAME OF DECEASED (Type or print) First Joseph Middle G. Last Roemer		4. DATE OF DEATH Month June Day 25 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 25, 1874
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Joseph Roemer, Jr., Port Penn, Del.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Acute coronary thrombosis DUE TO (b) Anterior wall Myocardial Infarction DUE TO (c) Coronary atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH None Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 15, 1960 to June 25, 1961 , that I last saw the deceased alive on June 2, 1961 , and that death occurred at 10:00 A.M. from the causes and on the date stated above			
ACTUAL SIGNATURE Ralph Andrews Jr. M.D.		ADDRESS (Street, city or town, state) 237 E. Main St. Elkton, Maryland	
PHYSICIAN'S NAME (Type) J. RALPH ANDREWS JR. M.D.		DATE SIGNED 6/25/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/28/61	22c. NAME OF CEMETERY OR CREMATORY Old Drawer's Cemetery	22d. LOCATION (City, town, or county) (State) Odesa, Del.
23. FUNERAL DIRECTOR'S SIGNATURE Donald M. Gee		24a. REC'D BY REGISTRAR Arthur S. Kraus	
ADDRESS Donald M. Gee, Pippin Funl. Home, Md.		DATE JUN 27 '61	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06687

1
FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH
a. COUNTY

Cecil

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

North East

c. LENGTH OF STAY IN 1b

all life

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

45 Beach St

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)

a. STATE

b. COUNTY

Md.

Cecil

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

North East

d. STREET ADDRESS

45 Beach St.

e. IS RESIDENCE ON A FARM?
YES ☐ NO ☒

3. NAME OF DECEASED
(Type or print)

Joseph

Wyoming Shallercross

4. DATE OF DEATH

Month

Day

Year

6

11

19 61

5. SEX

M

6. COLOR OR RACE

W

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐

8. DATE OF BIRTH

4-18-1906

9. AGE (In years last birthday)

55 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Clerk

10b. KIND OF BUSINESS OR INDUSTRY

Railroad

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Joseph Deal Shallercross

14. MOTHER'S MAIDEN NAME

Mary Ellen Bartley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)

16. SOCIAL SECURITY NO.

716-01-7831

17. INFORMANT

Almetia Shallercross, North East, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Perforating wound of the head

INTERVAL BETWEEN ONSET AND DEATH

716X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

Shot self with a revolver in the head.

20c. TIME OF INJURY
Hour a.m.

Month, Day, Year

10-25-61

6-11-61

20d. INJURY OCCURRED
While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

Home

20f. (City or town)

North East

(County)

Cecil

(State)

Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

R.C. Dodson

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

Rising Sun, Md.

DATE SIGNED

6-12-61

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF

Burial 6-14-1961

22c. NAME OF CEMETERY OR CREMATORY

North East Methodist

22d. LOCATION (City, town, or country)

North East Cecil Co. Md

23. FUNERAL DIRECTOR

ADDRESS

Joseph R Grant North East Md

24a. REC'D BY REGISTRAR

DATE JUN 14 '61

24b. REGISTRAR'S SIGNATURE

Arthur S. House

THIS MEDICAL EXAMINER'S CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THIS CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER'S OFFICE ALONG WITH FORM PM-3. PAGE 5 MAY BE RETAINED FOR YOUR FILES. IF FINAL DISPOSITION: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. FILE PAGES 1 AND 2 WITH THE STATE BOARD OF HEALTH, OR ITS DESIGNATED AGENT, PRIOR TO BURIAL, CREMATION, OR REMOVAL, AND IN ANY EVENT WITHIN 72 HOURS AFTER DEATH.

To

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1
FOR STATE
HEALTH DEPT.

TO DEPUTY CHIEF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

M

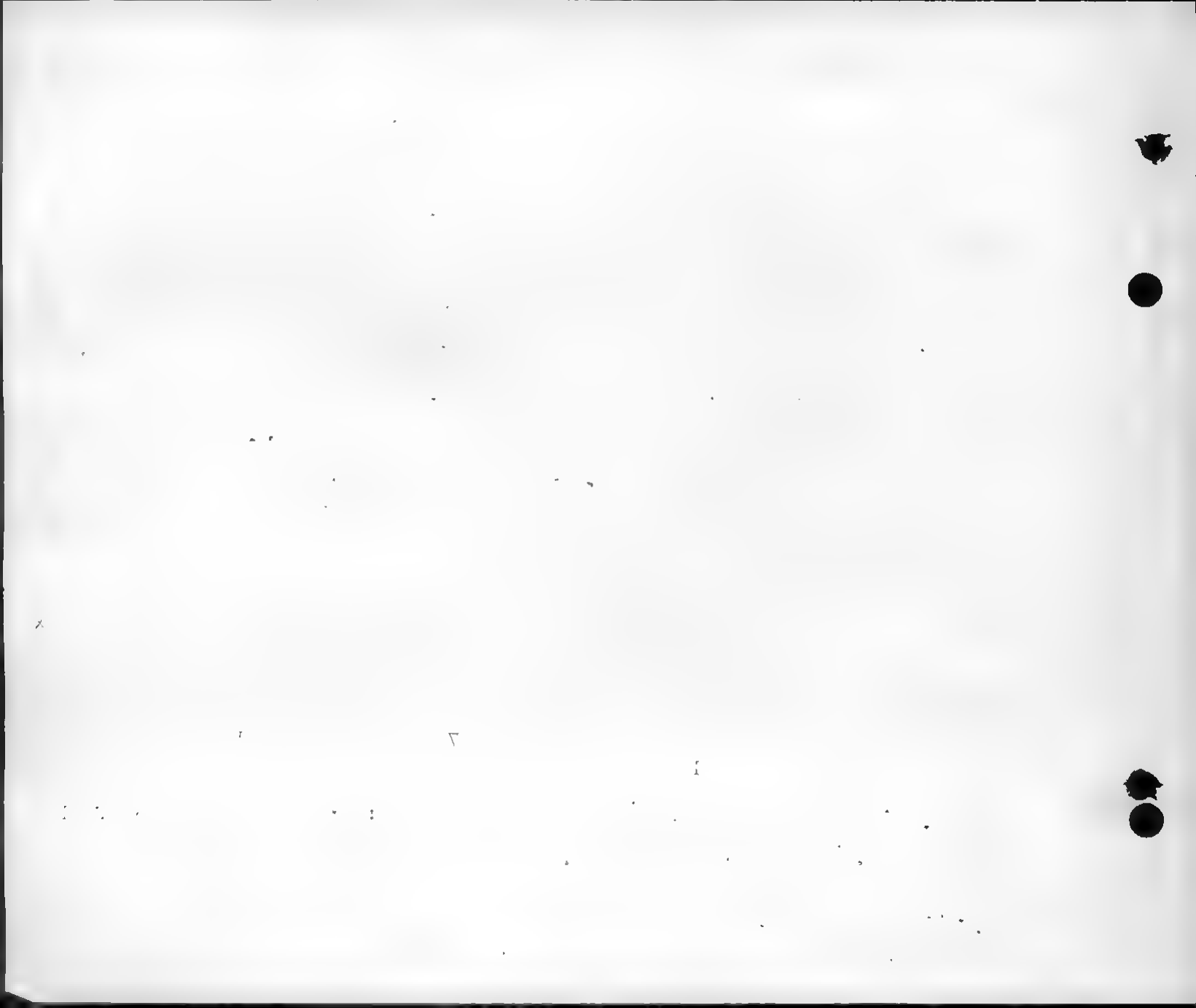
MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Cecil					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Harford				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perry Point					c. LENGTH OF STAY IN b 7yrs.2mo.18days				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital					d. STREET ADDRESS 369 Catherine				
3. NAME OF DECEASED (Type or print) WALTER T. SLOAN					4. DATE OF DEATH Month June Day 25 Year 1961				
5. SEX Male					6. COLOR OR RACE White				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH 10-14-89				
9. AGE (In years last birthday) 71 yrs.					10. AGE (In years last birthday) 71 yrs.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator					10b. KIND OF BUSINESS OR INDUSTRY Elevator				
11. BIRTHPLACE (State or foreign country) Maryland					12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME John L. Sloan (deceased)					14. MOTHER'S MAIDEN NAME Ellen Johnston (deceased)				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW-I					16. SOCIAL SECURITY NO. Not available				
17. INFORMANT Hospital Records, VAH, Perry Point, Md.					18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1. Bronchopneumonia, bilateral, unresolved. DUE TO (b) 2. Arteriosclerotic heart disease. DUE TO (c) 3. Arteriosclerosis, generalized.				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20e. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>R. C. Dodson</i>					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) R. C. DODSON					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL					22b. DATE THEREOF 6/29/1961				
22c. NAME OF CEMETERY OR CREMATORY Baltimore National					22d. LOCATION (City, town, or country) (State) Baltimore, Maryland				
23. FUNERAL DIRECTOR <i>Pennington & Son, Havre de Grace, Md.</i>					24a. REC'D BY REGISTRAR DATE JUL 5 '61				
					24b. REGISTRAR'S SIGNATURE <i>Charles S. Evans</i>				

66688

6-26-61

211- 1111



6706

CERTIFICATE OF DEATH

00580

Reg. Dist. No.

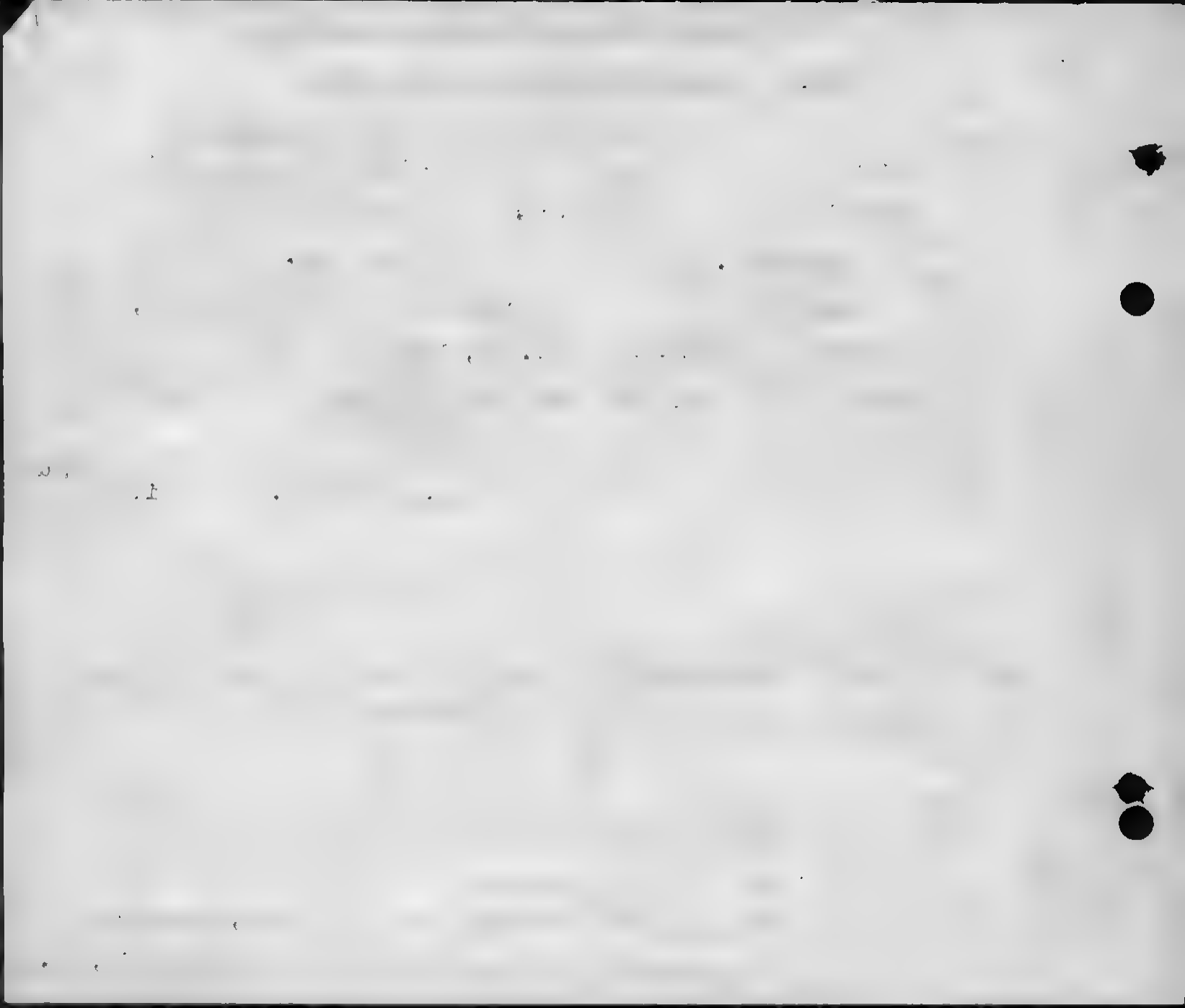
1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Cecil		MARYLAND		STATE Maryland		COUNTY Cecil	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Perryville		LENGTH OF STAY (In this place) 3 1/2 Yrs.		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Perryville			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Aikin Ave.				STREET ADDRESS (If rural give location) Aikin Ave.			
3. NAME OF DECEASED (Type or Print) Charles Stuchlik				4. DATE OF DEATH (Month) (Day) (Year) June 12, 1961			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Nov. 28, 1876	9. AGE last birthday 84 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Self Employed		11. BIRTHPLACE (State or foreign country) Czechoslovakia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. 222-24-1179		17. INFORMANT & ADDRESS Perryville, Md. Mrs. Anthony P. Lombardi			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
177X IMMEDIATE CAUSE (A) Carcinoma of Prostate				3 yrs			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH Arterio-Sclerosis							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan-8, 1961 to June 12, 1961 , that I last saw the deceased alive on June 12, 1961 , and that death occurred at 10:45 P.M. from the causes and on the date stated above.							
SIGNATURE Clarence Johnson M.D.				ADDRESS (Street, city, town, state) P.O. Box 210 - Perryville, Md.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF June 15, 1961		NAME OF CEMETERY OR CREMATORY Odd Fellows Cemetery		LOCATION (City, town, or county) (State) Milton, Delaware	
24. REC'D BY REGISTRAR JUN 15 '61		REGISTRAR'S SIGNATURE Arthur S. Kraus		25. FUNERAL DIRECTOR'S SIGNATURE W. A. Patterson & Son ADDRESS Perryville, Md.			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 WAK



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 06691

6707

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton	
c. LENGTH OF STAY IN 1b 10 Yrs		d. STREET ADDRESS 224 East Main St	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Devine Haven Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Elizabeth Evans Taggart		4. DATE OF DEATH Month 6 Day 6 Year 19 61	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Nov. 14 1899
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Savannah Ga.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James F. Evans		14. MOTHER'S MAIDEN NAME Bessie Scott	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Rudolph Y. Taggart Jr.		Address Elkton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple sclerosis DUE TO X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1, 19 61, to June 6, 19 61, that I last saw the deceased alive on June 5, 19 61, and that death occurred at 4:30 A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE S. RALPH ANDREWS, JR. M.D.		ADDRESS (Street, city or town, state) 227 E. MAIN ST. ELKTON, MARYLAND	
DATE SIGNED June 6, 19 61			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/8/1961	
22c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery		22d. LOCATION (City, town, or county) (State) Elkton MD.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Walter du Bose, Jr.		ADDRESS Elkton, Maryland.	
24a. REC'D BY REGISTRAR DATE 12 '61		24b. REGISTRAR'S SIGNATURE Charles E. Hanna	

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 06692

6708

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Penna.</u> b. COUNTY <u>York</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Rising Sun</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fawn Grove</u>	
c. LENGTH OF STAY IN 1b <u>5 months</u>		d. STREET ADDRESS <u>None</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Graybeal's Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>IDA</u> Middle <u>ELIZABETH</u> Last <u>WARNER</u>		4. DATE OF DEATH Month <u>June</u> Day <u>21</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 17, 1880</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Canning Factory</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fawn Grove, PA.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>James E. Anderson</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. McDermott</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>205-22-3899</u>	
17. INFORMANT <u>Mary Butchyard</u>		Address <u>Northeast, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Decompensation</u> <u>720.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>5 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/12</u> , 19 <u>61</u> , to <u>6/21</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>6/19</u> , 19 <u>61</u> , and that death occurred at <u>6:00</u> M., from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>Rising Sun, Md</u> DATE SIGNED <u>6/23/61</u> ACTUAL SIGNATURE <u>Neil Taylor Jr</u> M.D. PHYSICIAN'S NAME (Type) <u>Rising Sun, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-24-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fawn Grove Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Fawn Grove, York County, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth W. Orshurn</u>		ADDRESS <u>Stewartstown, Pa.</u>	
24a. REC'D BY REGISTRAR <u>June 26 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Kenna</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN. The form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed in by the funeral director, TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6709

Item 7 k... 7/17/61 iwk

CERTIFICATE OF DEATH

Reg. Dist. No. 06693

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>				c. LENGTH OF STAY IN 1b <u>30 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Union Hospital</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mildred</u> Widened <u>B</u> <u>Waters</u>				4. DATE OF DEATH Month <u>June</u> Day <u>13</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 23, 1905</u>	
9. AGE (In years lost birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Cecilton, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>John Briscoe</u>				14. MOTHER'S MAIDEN NAME <u>Ida Brown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown)		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Clifton Waters</u>		Address <u>Cecilton, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-Vascular accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Uremia</u> DUE TO (c) <u>Failure of left kidney</u>							INTERVAL BETWEEN ONSET AND DEATH <u>7 yrs.</u> <u>one year</u> <u>one year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Probable Tbc of remaining kidney left side, with uremia</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 2</u> , 19 <u>61</u> , to <u>June 13</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>13 June</u> , 19 <u>61</u> , and that death occurred at <u>5:00P</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Wallace Obenshain</u> M.D. <u>13 June 61</u> PHYSICIAN'S NAME (Type) <u>Wallace Obenshain, M.D.</u> <u>Cecilton, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/17/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bohemia Manor, Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Bohemia Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Beale</u>				ADDRESS <u>909 Poplar St.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 19 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>Charles E. Hume</u>			



FOR STATE
HEALTH DEPT.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or in any event, within 72 hours after death.

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1. PLACE OF DEATH a. COUNTY <u>Cecil</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Elkton</u> c. LENGTH OF STAY IN 1b <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Union Hospital of Cecil County</u>				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>ecil</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Chesapeake, R. I. 1</u> d. STREET ADDRESS <u>Rural</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Addie</u> <u>Elizabeth</u> <u>Webb</u>				4. DATE OF DEATH Month Day Year <u>June</u> <u>20</u> <u>19 61</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 8, 1925</u>	
9. AGE (In years last birthday) <u>35</u> yrs.		IF UNDER 1 YEAR Months Days <u>0</u> <u>0</u>		IF UNDER 24 HRS. Hours Min. <u>0</u> <u>0</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Thomas G. Garnett</u>				14. MOTHER'S MAIDEN NAME <u>Susie Braxton</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>10</u>		17. INFORMANT <u>Ramond F. Webb</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary occlusion</u> <u>7201</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Hypertension</u> (c) <u>DUE TO</u> (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>10 min</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>1512 3rd St. Cecil, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/24/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bohemia Manor Cem.</u>		22d. LOCATION (City, town, or country) (State) <u>Bohemia Manor, Md.</u>	
23. FUNERAL DIRECTOR <u>Wm. P. Bell</u> ADDRESS <u>909 Poplar St.</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 23 '61</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Fland</u>	

MEDICAL CERTIFICATION

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

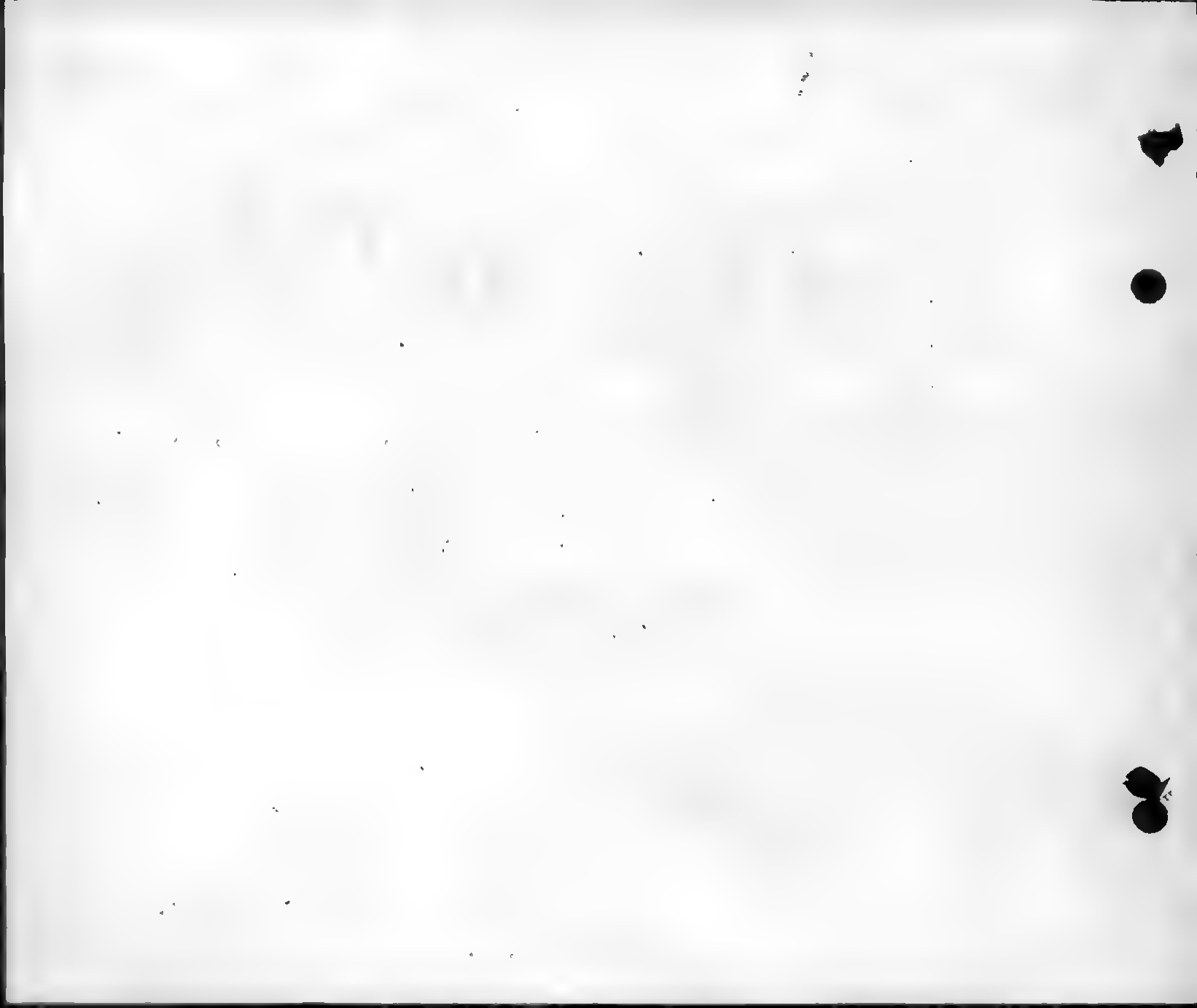
CERTIFICATE OF DEATH

Reg. Dist. No. 06695

6711

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Libton		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Cecil c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Liberty Grove	
c. LENGTH OF STAY IN lb 8 Days		d. STREET ADDRESS RFD	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ida Middle C. Last Wiggins		4. DATE OF DEATH Month June Day 4 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-24-1880
9. AGE (In years and birthday) 80 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank Chambers		14. MOTHER'S MAIDEN NAME Katherine Fite	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
INFORMANT Lewis Wiggins, Rising Sun, Md. Rural		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Bronchopneumonia Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Coronary Heart Disease (c) Atherosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus			
INTERVAL BETWEEN ONSET AND DEATH 1 week			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-24-1961 to 12-24-1961 , that I last saw the deceased alive on 12-24-1961 , and that death occurred at 11 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Port Deposit, Md. DATE SIGNED 12-24-1961			
ACTUAL SIGNATURE Ida C. Wiggins M.D.		PHYSICIAN'S NAME (Type) Ida C. Wiggins	
22a. BURIAL, CREMATION, REINTERMENT (Specify) Burial		22b. DATE THEREOF 6-8-1961	
22c. NAME OF CEMETERY OR CREMATORY hopewell Cemetery		22d. LOCATION (City, town or county) (State) Port Deposit, Md. Rural	
23. FUNERAL DIRECTOR'S SIGNATURE Lee A. Patterson & Son, ADDRESS Perryville, Md.		24a. REC'D BY REGISTRAR DATE JUN 7 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. K...			

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6712

06696

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perry Point c. LENGTH OF STAY IN 1b 30 yrs. 5 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE North Carolina b. COUNTY Beaufort c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS RFD #1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First GUY Middle A. Last WILLARD			4. DATE OF DEATH Month June Day 6 Year 19 61				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH 11-28-98		9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months 62 Days 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (County & State, or foreign country) North Carolina			
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Not available from records			14. MOTHER'S MAIDEN NAME Not available from records				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW-1		17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema & congestion, severe DUE TO (b) Arteriosclerotic heart disease, severe Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Arteriosclerosis generalized severe - unknown							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis generalized severe - unknown							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. VA p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		20g. (County)		20h. (State)			
21. I certify that XXXXXX attended the deceased from May 1, 1961 to June 6, 1961 and that death occurred 9:44pm from the causes and on the date stated above.							
22a. SIGNATURE A.L. Mooney				22b. DATE SIGNED 6-7-61			
22c. PHYSICIAN'S NAME (Type) A.L. MOONEY Asst. Clinical Pathologist, V.A. Hospital, Perry Point, Md.				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE THEREOF 6/8/1961		23c. NAME OF CEMETERY OR CREMATORY Oakdale			
23d. LOCATION (City, town or county) Washington, N. C.		23e. REC'D BY REGISTRAR JUN 12 '61					
24. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son		24b. ADDRESS Harvey de Grace, Md.		24c. REGISTRAR'S SIGNATURE William E. House			

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Not available from records

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Ministry of Health & Social Services, Ottawa

Ministry of Health & Social Services, Ottawa

Ministry of Health & Social Services - Ottawa

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Washington, D.C.

Washington, D.C.

Handwritten notes and signatures at the bottom of the page.

TO HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. Page 1 is retained by the hospital or attending physician. Page 2 is retained by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6713

06697

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perry Point c. LENGTH OF STAY IN 1b 2 mo. 11 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Cecil c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Elkton d. STREET ADDRESS R.D. #5 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) FRANK (NMI) YOCUM		4. DATE OF DEATH Month Day Year June 29 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-18-79
9. AGE (in years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Box Maker		10b. KIND OF BUSINESS OR INDUSTRY Factory	11. BIRTHPLACE (County & State, or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Joseph T. Yocum (deceased)	
14. MOTHER'S MAIDEN NAME Catherine Spence (deceased)		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes S.A.W.	
16. SOCIAL SECURITY NO. None		17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized abdominal carcinomatosis 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of the rectum DUE TO (c) unknown		INTERVAL BETWEEN ONSET AND DEATH unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that XXXXXX attended the deceased from April 18, 1961 to June 29, 1961 and that death occurred 6:30am from the causes and on the date stated above.			
22a. SIGNATURE A. L. Mooney M.D. 22c. PHYSICIAN'S NAME (Type) A. L. MOONEY, Asst. Clinical		22b. DATE SIGNED 6-29-61 22d. ADDRESS Pathologist, V.A. Hospital, Perry Point, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) 7/4/61		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY Cherry Hill		23d. LOCATION (City, town or county) (State) Cherry Hill, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son, Havre de Grace, Md.		25a. REC'D BY REGISTRAR DATE JUL 5 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Hines			

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